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A Conundrum for Corrections, A Tragedy for Prisoners: Prisons as Facilities for the Mentally Ill

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Any analysis of violence and abuse in American prisons must address the consequences of the high rates of incarceration of offenders with mental illness and the poor treatment they receive behind bars. Human Rights Watch has been researching conditions in American prisons for over a decade, and most recently we have undertaken research on the issue of mental illness. In 2003 we published a report, *Ill Equipped: U.S. Prisons and Offenders with Mental Illness*.¹

More than half of all prison and jail inmates nationwide—some 1,255,000 men and women—have mental health problems.² Many suffer from mental disorders, including such serious illnesses as schizophrenia, bipolar disorder, and major depression.³ An estimated

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1. SASHA ABRAMSKY & JAMIE FELLNER, HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* (Joseph Saunders & James Ross eds., 2003). While the report is based on research conducted between 2001 and 2003, everything we have learned since then suggests its findings, and its recommendations, remain equally valid today.

2. DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 213600, *MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES* 3 tbl.2 (2006).

3. In 2000 the American Psychiatric Association reported research estimates that perhaps as many as one in five prisoners were seriously mentally ill. AM. PSYCHIATRIC ASS'N, *PSYCHIATRIC SERVICES IN JAILS AND PRISONS*, at xix (2d ed. 2000). Based on these numbers, and a population of 1,361,258 in state and federal prisons, per a 2002 Bureau of Justice Statistics report, approximately 300,000 prisoners might be seriously mentally ill. PAIGE M. HARRISON & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 200248, *PRISONERS IN 2002*, at 1 (2003); see also *Impact of Mentally Ill Offenders on the Criminal Justice System: Hearing Before the Subcomm. on Crime of the H. Comm. on the Judiciary*, 106th Cong. 10 (2000) (statement of Rep. Strickland); NAT'L COMM'N ON CORR. HEALTH CARE, *THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS* 22 (Mar. 2002), available at [http://www.ncchc.org/stbr/Volume1/Health%20Status%20\(vol%201\).pdf](http://www.ncchc.org/stbr/Volume1/Health%20Status%20(vol%201).pdf).

one hundred thousand are psychotic on any given day.⁴ Indeed, one of the primary roles of prisons in the United States today is to house the mentally ill. Prisoners have rates of mental illness that are two to four times greater than the rates of members of the general public.⁵

Prisons were never intended to function as mental health facilities. The growing number of mentally ill persons who are incarcerated in the United States is an unintended consequence of two distinct public policies that have prevailed over the last thirty years. The first policy is one of indifference toward community mental health needs. Elected officials have failed to provide adequate funding, support, and direction for the community mental health systems that were supposed to replace the mental health hospitals shut down as part of the “deinstitutionalization” effort that began in the 1960s.⁶ People with serious mental illnesses—particularly those who are also poor, homeless, and suffering from untreated alcoholism or drug addiction—usually cannot obtain the mental health treatment they need. Left untreated and unstable they enter the criminal justice system when they break the law. Most of their crimes are minor public order or nuisance crimes, but some are felonies which lead to prison sentences.⁷

4. In 2000 the American Psychiatric Association reported that up to 5% of prisoners were actively psychotic at any given moment. AM. PSYCHIATRIC ASS'N, *supra* note 3, at xix. Based on these numbers, and the previously mentioned population of 1,361,258 in state and federal prisons, approximately 70,000 prisoners might be actively psychotic. HARRISON & BECK, *supra* note 3, at 1.

5. Jeffrey L. Metzner et al., *Treatment in Jails and Prisons*, in TREATMENT OF OFFENDERS WITH MENTAL DISORDERS 211 (Robert M. Wettstein ed., 1998). Dr. Metzner also provides a summary of research on the prevalence of mental disorders in jails and prisons. *Id.* at 230–33. The (formerly known) National Alliance for the Mentally Ill and the Center for Mental Health Services estimate that as much as 5.4% of adults in the United States have some form of serious mental illness. NAMI, About Mental Illness, http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm (last visited Sept. 12, 2006).

6. ABRAMSKY & FELLNER, *supra* note 1, at 19–23; see also PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 4 (July 2003). In 2005 61% of state prisoners with mental health problems were convicted of non-violent offenses, including 19.3% for drugs. JAMES & GLAZE, *supra* note 2, at 7 tbl.8.

7. For statistics supporting this proposition see PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 174463, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (1999).

Second, elected officials have embraced a punitive anti-crime effort, including a national “war on drugs,” that has dramatically expanded the number of persons brought into the criminal justice system, the number of prison sentences given for nonviolent crimes (particularly drug and property offenses), and the length of sentences.⁸ Prison and jail populations have soared, more than quadrupling in the last thirty years.⁹ A considerable proportion of that soaring prison population consists of the mentally ill; studies indicate that somewhere between 8% and 20% of the prison population have significant psychiatric disabilities.¹⁰

Corrections systems have not been able to keep up with the exploding prison population, much less the exploding population of offenders with mental illnesses. Many, if not most, prison mental health services are woefully deficient. They are crippled by understaffing, insufficient facilities, limited programs, and the restrictions imposed on them by prison rules and prison culture. All too often, seriously ill prisoners receive little or no meaningful treatment. They are neglected, accused of malingering, or are treated as disciplinary problems.

Without the necessary care mentally ill prisoners suffer painful symptoms and their conditions can deteriorate. They are afflicted with delusions and hallucinations, debilitating fears, and extreme and uncontrollable mood swings. They huddle silently in their cells and mumble incoherently or yell incessantly. They refuse to obey orders or lash out without provocation. They assault other prisoners or staff. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit suicide.

Compared to the state of correctional mental health care a few decades ago, there has been enormous improvement. Federal court rulings made it clear that correctional authorities could not simply ignore the mental health needs of prisoners.¹¹ In prisons across the country today there are competent and committed mental health

8. ABRAMSKY & FELLNER, *supra* note 1, at 13.

9. *Id.* at 17–19.

10. *See, e.g.*, Metzner et al., *supra* note 5, at 11.

11. *See* Farmer v. Brennan, 511 U.S. 825, 833 (1994); Estelle v. Gamble, 429 U.S. 97, 104 (1976).

professionals who struggle to provide good mental health services to those who need them. But they face daunting obstacles: far too limited resources; corrections officials who resent or begrudge their work; and lack of both decent pay and public recognition.

Yet some prisons continue to reflect deep-rooted patterns of neglect, mistreatment, and even cavalier disregard for the well-being of vulnerable and sick human beings. A federal district judge, referring in 1999 to conditions in Texas' prisons, made an observation that is still too widely applicable: "Whether because of a lack of resources, a misconception of the reality of psychological pain, the inherent callousness of the bureaucracy, or officials' blind faith in their own policies, the [corrections department] has knowingly turned its back on this most needy segment of its population."¹²

In the most extreme cases conditions are truly horrific: mentally ill prisoners are locked in segregation with no treatment at all; confined in filthy and beastly hot cells; left for days covered in feces they have smeared over their bodies; taunted, abused, or ignored by prison staff; given so little water during summer heat waves that they drink from their toilet bowls.¹³ A prison expert described one prison unit holding many mentally ill prisoners as "medieval . . . cramped, unventilated, unsanitary . . . it will make some men mad and mad men madder."¹⁴ Suicidal prisoners are left naked and unattended for days on end in barren, cold observation cells.¹⁵ Poorly trained

12. Ruiz v. Johnson, 37 F. Supp. 2d 855, 914 (S.D. Tex. 1999), *rev'd*, 178 F.3d 385 (5th Cir. 1999).

13. See Russell v. Johnson, 210 F. Supp. 2d 804, 807 (N.D. Miss. 2002) (denying petitioners' application for a preliminary injunction to temporarily postpone petitioners' execution to allow petitioners' counsel and experts to tour death row); see also Report of Dr. Dennis Koson for Plaintiffs, C.F. v. Terhune, No. 96-1840 (D.N.J. Sept. 8, 1998), available at http://hrw.org/reports/2003/usa1003/New_Jersey_Expert_Report_Koson.pdf.

14. Fred Cohen, Expert's Report: Mental Health Care in the Alabama Department of Corrections 51 (unpublished statement on file at Human Rights Watch).

15. See, e.g., Complaint, Disability Advocates, Inc. v. N.Y. State Office of Mental Health, No. 02 CV 4002 (S.D.N.Y. May 28, 2002), available at http://hrw.org/reports/2003/usa1003/NYS_Disability_Advocates_Complaint.pdf; Expert Report of Kathryn Burns & Jane Haddad for Plaintiffs at 28, Bradley v. Hightower, No. 92-A-70-N (N.D. Ala. June 30, 2000), available at http://hrw.org/reports/2003/usa1003/Alabama_Expert_Report_Hightower.pdf; Interview with Y.P., in Seattle, Wash. (Aug. 20, 2002).

correctional officers have accidentally asphyxiated mentally ill prisoners whom they were trying to restrain.¹⁶

Offenders who need psychiatric interventions for their mental illness should be held in secure facilities if they have committed serious crimes and pose a danger to the community, but those facilities should be designed and operated to meet treatment needs. Society gains little from incarcerating mentally ill offenders in environments that are, at best, counter-therapeutic and, at worst, dangerous to their mental and physical well being.

Doing time in prison is hard for everyone. Prisons are tense and overcrowded facilities in which all prisoners struggle to maintain their self-respect and emotional equilibrium despite violence, exploitation, extortion, and lack of privacy; stark limitations on family and community contacts; and a paucity of opportunities for meaningful education, work, or other productive activities. But doing time in prison is particularly difficult for prisoners with mental illnesses that impair their thinking, emotional responses, and ability to cope. Compared to other prisoners, moreover, prisoners with mental illnesses also are more likely to be exploited and victimized by other inmates.¹⁷ They are also twice as likely to be injured in a fight.¹⁸

Mental illness can make it particularly difficult to handle the extraordinary stress of prison and to obey the many rules of an extremely regimented life. Prisoners with mental illness have higher rates of rule-breaking (in prison argot, “disciplinary infractions”).¹⁹

16. Telephone Interview with Steve J. Martin, Attorney, in Austin, Tex. (Oct. 1, 2002). Further description of such an event can be found in ABRAMSKY & FELLNER, *supra* note 1, at 80.

17. See, e.g., VICTOR HASSINE, *LIFE WITHOUT PAROLE: LIVING IN PRISON TODAY* (Robert Johnson & Thomas J. Bernard eds., 3d ed. 2003); TERRY KUPERS, *PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT* (1999); Lance Couturier & Frederick R. Maue, *Suicide Prevention Initiatives in a Large Statewide Department of Corrections: A Full-Court Press to Save Lives*, 9 *JAIL SUICIDE/MENTAL HEALTH UPDATE* 1, 2 (2000); JENNIFER R. WYNN ET AL., CORR. ASS'N OF N.Y., *MENTAL HEALTH IN THE HOUSE OF CORRECTIONS* (Gail Allen et al. eds., 2004); Report of Cheryl D. Wills at 16, *Laube v. Haley*, 234 F. Supp. 2d 1227 (M.D. Ala. 2002).

18. JAMES & GLAZE, *supra* note 2, at 10 tbl.16. Approximately 57% of state inmates with a mental health problem have been charged with a disciplinary infraction, compared to 43.2% of other inmates. *Id.*

19. ABRAMSKY & FELLNER, *supra* note 1, at 59–60.

Yet they are punished for breaking the rules the same as other prisoners, even when their misconduct results from their mental illness. Even their acts of self-mutilation and suicide attempts are too often seen as “malingering” and are punished as rule violations. As a result, mentally ill prisoners can accumulate extensive disciplinary histories.

Security staff typically view mentally ill prisoners who break rules and act out as difficult and disruptive. Whether as punishment or simply an administrative housing decision officials often place them in barren high-security solitary confinement units. The lack of human interaction and the limited mental stimulus of twenty-four-hour-a-day life in small, sometimes windowless segregation cells, coupled with the absence of adequate mental health services, dramatically aggravate the suffering of the mentally ill. Some deteriorate so severely that they must be removed to hospitals for acute psychiatric care. But after being stabilized they are returned to the same segregation conditions, and the cycle of decompensation begins again.²⁰ The penal network is thus not only serving as a warehouse for the mentally ill, but, by relying on extremely restrictive housing for mentally ill prisoners, it is acting as an incubator for psychiatric breakdowns.

International human rights law and standards specifically address conditions of confinement, including the treatment of mentally ill prisoners. If, for example, United States officials honored in practice the International Covenant on Civil and Political Rights,²¹ to which the United States is a party, and the United Nations’ Standard Minimum Rules for the Treatment of Prisoners,²² which set out detailed guidelines on how prisoners should be treated, practices in American prisons would improve considerably. These human rights documents affirm the human dignity of prisoners, their right not to be subjected to cruel, inhuman, or degrading conditions of confinement

20. “Decompensation” refers to the aggravation of symptoms of mental illness leading to a marked deterioration from previously adequate levels of functioning and coping in daily life.

21. International Covenant on Civil and Political Rights, G.A. Res. 2200A, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc A/6316 (Dec. 16, 1966).

22. Standard Minimum Rules for the Treatment of Prisoners, E.S.C. Res. 663C, U.N. ESCOR, 1st Sess., Supp. No. 1, U.N. Doc E/3048 (Aug. 30, 1955), *amended* by E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, U.N. Doc E/5988 (May 13, 1977).

and the right to mental health treatment consistent with community standards of care. That is, human rights standards do not permit corrections agencies to ignore or under-treat mental illness just because a person is incarcerated. The Eighth Amendment to the Constitution of the United States, which prohibits cruel and unusual punishment,²³ also provides prisoners a right to humane conditions of confinement, including mental health services for serious illnesses.²⁴

Prisoners are not, however, a powerful public constituency, and legislative and executive branch officials typically ignore their rights absent litigation or the threat of litigation. Reservations harbored by the United States to international human rights treaties preclude the ability of prisoners to bring suit based on violations of their treaty rights. Lawsuits under the Constitution can only accomplish so much. Under current constitutional jurisprudence, poor mental health care only constitutes an Eighth Amendment violation when officials are “deliberately indifferent” to prisoners’ known and serious mental health needs.²⁵ Neither medical neglect nor medical malpractice are violations of the Constitution.²⁶ Finally, the misguided Prison Litigation Reform Act,²⁷ enacted in 1996, has seriously hampered the ability of prisoners to achieve effective and timely help from the courts.

Mental health treatment can help some people recover from their illness, and for many others it can alleviate painful symptoms. It can enhance independent functioning and encourage the development of more effective internal controls. In the context of prisons, mental health services play an even broader role: by helping individual prisoners regain health and improve coping skills, they promote safety and order within the prison community and offer the prospect of enhancing community safety when the offenders are ultimately released.

The components of quality, comprehensive mental health care in prison are well known. They include: systematic screening for and

23. U.S. CONST. amend VIII.

24. *See Farmer v. Brennan*, 511 U.S. 825 (1994); *Estelle v. Gamble*, 429 U.S. 97 (1976).

25. *See Farmer*, 511 U.S. at 833; *Estelle*, 429 U.S. at 104.

26. *Estelle*, 429 U.S. at 106.

27. Prison Litigation Reform Act of 1995, Pub. L. No. 104-134 (codified as amended in scattered sections of 28 U.S.C.).

evaluation of mental illness; mechanisms to provide prisoners with prompt access to mental health personnel and services; a range of appropriate therapeutic interventions including, but not limited to, appropriate medication; a spectrum of levels of care including acute inpatient care and hospitalization, long-term intermediate care programs, and outpatient care; a sufficient number of qualified mental health professionals to develop individualized treatment plans and to implement such plans for all prisoners suffering from serious mental disorders; maintenance of adequate and confidential clinical records and the use of such records to ensure continuity of care as prisoners are transferred from jail to prison and between prisons; suicide prevention protocols for identifying and treating suicidal prisoners; and discharge planning that will provide mentally ill prisoners with access to needed mental health and other support services upon their release from prison. Peer review and quality assurance programs help ensure that proper policies on paper are translated into practice inside the prisons.²⁸

Many prison systems have good policies on paper but implementation can lag far behind. In recent years some prison systems have begun to implement system-wide reforms, often prompted by litigation, and innovative programs to attend to the mentally ill. Nevertheless, across the country seriously ill prisoners continue to confront a paucity of qualified staff who can evaluate their illness, develop and implement treatment plans, and monitor their conditions; they confront treatment that consists of little more than medication or no treatment at all; they remain at unnecessarily high risk for suicide and self-mutilation; they live in the chaos of the general prison population²⁹ or under the strictures of solitary confinement, with brief breaks in a hospital, because of the lack of specialized facilities that would provide the long-term, supportive, therapeutically oriented environment they need.

28. B. JAYE ANNO, NAT'L COMM'N ON CORR. HEALTH CARE, PRISON HEALTH CARE: GUIDELINES FOR THE MANAGEMENT OF AN ADEQUATE DELIVERY SYSTEM (1991).

29. Prisoners are part of the "general population" of a prison unless they have been placed in segregated or special housing units for such purposes as discipline, protective custody, security, or medical care.

Providing mental health services to incarcerated offenders is frustrated by a lack of resources. It is also frustrated by the realities of prison life and prison culture. Correctional mental health professionals work in facilities run by security staff according to rules never designed for or intended to accommodate the mentally ill. For example, mentally ill prisoners are consigned to segregated units even though the harsh, isolated confinement in such units can provoke psychiatric breakdown. Moreover, the rules designed by security staff for prisoners in solitary confinement prevent mental health professionals from providing little more than medication to the mentally ill confined in these units.³⁰ As a consequence, these professionals cannot provide much needed private counseling, group therapy, or structured activities.

Correctional staff who have the most contact with prisoners and who are often called upon to make decisions regarding their needs—particularly in the evenings when mental health staff are not present—often lack the training to recognize symptoms of mental illness, and to handle appropriately prisoners who are psychotic or acting in bizarre or even violent ways. It is easy for untrained correctional staff to assume an offender is deliberately breaking the rules or is faking symptoms of illness for secondary gain, such as to obtain a release from solitary confinement into a less harsh hospital setting.

Unfortunately, the judgment of some mental health professionals working in prisons becomes compromised over time. They become quick to find malingering instead of illness; to see mentally ill prisoners as troublemakers instead of persons who may be difficult but are nonetheless deserving of serious medical attention. The tendency to limit treatment to the most acutely and patently ill is also encouraged by a lack of resources. Because not everyone can receive appropriate treatment, mental health staff limit their attention to only a few.

There is growing recognition in the United States that the country can ill-afford its burgeoning prison population, and that, for many crimes, public goals of safety and crime reduction would be equally,

30. ABRAMSKY & FELLNER, *supra* note 1, at 154–61.

if not better, served by alternatives to incarceration, including drug and mental health treatment programs. Momentum is building, albeit slowly, to divert low-level nonviolent offenders from away prison—an effort that would benefit many of the mentally ill. But until the country makes radical changes in its approach to community mental health, as well as poverty and homelessness, there is every likelihood that men and women with mental illnesses will continue to be over-represented among prison populations. Steps must be taken now to ensure that prisons are humane and safe places for them.

Corrections officials recognize the challenge posed to their work by the large and growing number of prisoners with mental illness. They recognize they are being asked to serve a function for which they are ill-equipped. They need support in their efforts to ensure appropriate conditions of confinement and mental health services for the mentally ill men and women consigned to them. Political sentiments and public opinion must be marshaled to understand the need for enhanced mental health resources—for those in, as well as outside of, prison. The problems we have documented can be solved, but to do so requires drastically more public commitment, compassion, and common sense than have been shown to date.